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The Bristol Medico-Chirurgical Journal

A Journal of the Medical Sciences for the

West of England and South Wales

"Scire est nescire, nisi id me
Scire alius sciret."

JANUARY, 1949

OBSTETRICS AND GYNÆCOLOGY OLD AND NEW

The Presidential Address, delivered on Wednesday, 13th October, 1948, at the opening of the Seventieth Session of the Bristol Medico-Chirurgical Society

BY

H. J. Drew Smythe, M.C., T.D.

Professor of Obstetrics in the University of Bristol

In this address I want to take you from ancient to modern obstetrics and gynæcology, not to compare them but rather as medical history. It is said that the primitive races had little difficulty in childbirth, and that the same applies to uncivilized races in these days. This I doubt very much, having seen deliveries and the result of such deliveries in uncivilized races in the East. From ancient books of midwifery one reads of the means by which nature was encouraged to do her best, or worst. Any difficulty in the delivery of a primitive woman was not considered to be one of obstetrics, but due to the unwillingness of the child to be born. The child, therefore, for its unwillingness had to be destroyed, and needless to say the mother usually shared the same fate. Special instruments for destroying the child *in utero* were designed for this purpose.

The posture assumed by the primitive woman for the birth of the child was the squatting position, which is the natural position for bearing down. This position, or variations, have been used throughout the ages up to the present day. The first variation of this position was for the patient to sit between the knees of one

woman who clasped the patient round the waist, while another woman held the patient's bended knees. The next step was the introduction of the obstetric chair, which was part of the professional equipment of every midwife. This chair is mentioned in the first chapter of Exodus, when Pharaoh commands the midwives to slay all Jewish male infants : " When you do the office of midwife to the Hebrew women and see them upon the stool." The chair remained the necessary equipment of a midwife up to the nineteenth century. In the seventeenth century, however, Mariceau in France introduced the delivery of the patient in bed, though the midwives still used the obstetric chair with its attendant source of sepsis.

In more modern times a variation of this chair was the use of a commode during the first and early second stage of labour, which I hope has now been abandoned. The squatting position is still used in modern midwifery, but the patient lies on her back in bed with the knees drawn up. A different variation is used at the present time during the second stage of labour. The position is the same, but the patient, lying on her back or on her side, clasps the knees with the hands until the actual delivery of the head.

Many changes in the technique of delivery have taken place during the ages. It is true that primitive women were in a better position to have a normal labour than a large number of women in modern times, as they did not undergo the risks of civilization, namely, overcrowding, incorrect feeding in childhood, and sepsis at delivery. In spite of this, obstetric difficulties were bound to arise, and in ancient days assistance was of a direct nature. The patient was held up by the feet and well shaken, or rolled or bounced in a blanket. Other methods were to trample on the patient's abdomen : or the patient was hung up by the arms to a tree, while those assisting her bore down on a strap placed over the fundus of the uterus. Amongst the Red Indians the patient was placed out in the open plain, and a warrior galloped straight at her—avoiding the patient, we hope, at the last minute. This presumably was for its psychological effect. Then we have the medicine-man of a tribe, who would mumble some incantation, anoint the woman with saliva, or use some gruesome relic to do so : but he did not use any aids to midwifery, and the outcome was more or less successful.

Though rational midwifery was probably practised before the second century, it was at that time that the first work in midwifery was written. In this century Soranus of Ephesus wrote a work on midwifery and diseases of women, in which he taught sensible care and assistance to women in childbirth, based on practical and anatomical knowledge. He advocated podalic version as a means of delivering the child instead of destroying it with instruments. He however was not the first to practise this manœuvre, as it was described and practised by the Egyptians as early as 300 B.C.

PLATE I

An obstetrical chair of the fifteenth century.

Ancient methods of hastening labour.

PLATE II

An Indian brave hastening labour. Formerly among some of the tribes of American Indians labour was hastened by placing the woman on the prairie and having a horseman ride at her with the apparent intention of trampling her. Although the rider turned aside at the last moment the fear inspired in the woman was sometimes effective in shortening her labour.

The height of prudery. A physician operating under the sheet.

With acknowledgments to Wm. Heinemann (Medical Books) Ltd.

The custom for a physician to act as midwife ceased in western civilization in the fourth century, and from this date until a little over three hundred years ago midwifery passed into the hands of untrained midwives. Midwifery was not only ignored by the physician, but he was actually prohibited by custom and law from undertaking it. The result was that no advance in obstetrics took place until the sixteenth century, when the participation of the physician in midwifery came into limited favour again.

It is true that in the Middle Ages Roslin of Worms wrote the famous book entitled *The Garden of Roses for Pregnant Women and Midwives*. However, this is of historical interest only, in that it was the first book on midwifery written in Europe for fourteen centuries. It brought out nothing new, as one would expect, as Roslin had never seen a child born.

Modern midwifery commenced with Ambrose Paré in 1573. He re-introduced podalic version for delivery, and opposed Cæsarean section. Cæsarean section had been used for many centuries to deliver the child from the mother who died in childbirth, but there is no record of this operation having been performed on the living until the fifteenth or sixteenth centuries. In Paré's day, it was attended with a high mortality, and hence his preference for podalic version. Paré also started a school for midwives in Paris, and this was the first training-school for midwives. It was not until the eighteenth century, two hundred years later, that a similar school was started by Smellie in London.

In the seventeenth century two happenings brought the physician back into midwifery. In France the physician Boucher was summoned to attend Louis XIV's mistress, La Vallière. This apparently was a successful delivery, as in 1670 Clement, another physician, attended Madame Montespan, and in 1682 the Queen of France. These births must have been successful also, for the title of accoucheur was conferred on Clement, instead of the derisive title of "man-midwife" or "mid-man". The title of accoucheur was given to obstetricians in this country until quite modern times.

In England, at about the same period as Paré, Chamberlain invented the obstetric forceps. As these were a family secret it was necessary to call in a Chamberlain to use them, and by this means in this country also the physician came back to obstetrics. The history of the Chamberlain forceps is interesting. They were probably invented by Peter Chamberlain in 1600, and his original forceps were found in a secret cupboard in his house one hundred and fifty years after his death. Peter Chamberlain was followed by his son Hugh, who translated Mariceau's *Midwifery* into English, and visited Mariceau in Paris. While in Paris he demonstrated his forceps on one of Mariceau's patients, and unfortunately, as so often

happens when one is demonstrating an operation or technique, things went wrong and the patient died from a ruptured uterus. In later years Hugh Chamberlain got mixed up in politics and the Land Bank, and in consequence lost a fortune and fled to Holland. In Holland he craftily sold one blade only of his forceps to the Dutch physician Roonhuysen: he had previously tried unsuccessfully to sell them to Mariceau. All Hugh's sons practised midwifery in England, and as the forceps were a family secret they made large fortunes.

The re-introduction of the physician into midwifery met with considerable opposition from the midwives, and Smellie was described by one as "a great horse godmother of a he-midwife". Difficulties were also encountered from the prudery of patients, other than those in royal circles among whom modesty was not carried to this extent. Louis XIV is said to have shown his interest in the delivery of his mistress by watching the procedure from the concealment offered by some curtains. On the other hand, the early physicians were forced frequently to serve their prudish patients "under the sheet". One end of a sheet was tied to the patient's waist, and the other around the physician's neck. He made his examinations and delivery blindly beneath this covering.

In 1651 William Harvey wrote the first scientific description of generation and labour, and in the eighteenth century Smellie published the first exact measurements of the pelvis, and introduced the modern forceps blade. In the same century induction of premature labour was introduced for contracted pelvis, though the old Hippocratic belief that a child born at seven months had a better chance of survival than one born later was still held. This belief is even now a popular superstition.

In 1858 Semmelweis in Vienna discovered that puerperal fever was caused by infection, and about the same time Oliver Wendell Holmes in America was preaching the same thing. In the same decade the work of Lister completed that which Semmelweis had started.

The introduction of antiseptics and anæsthetics began the modern advance in obstetrics, but even thirty-five years ago the examiners' table was full of instruments for the destruction of the child rather than for its delivery alive. Obstructed labour and obstetrical tragedies were not uncommon in my early days on the staff, high forceps delivery was common, and for minor degrees of flat pelvis podalic version was performed. Cæsarean section held a moderate mortality from abdominal sepsis in those days, and hence vaginal delivery, however difficult, was preferred to abdominal. At the present time obstructed labour and serious obstetrical complications are uncommon. This I feel certain is due to the following: ante-

natal supervision, the correct measurement of the pelvis by X-rays, the estimation of cephalo-pelvic disproportion, induction of labour and trial labour, and last but not least the modern method of delivery of breech presentation. The introduction of the Sulphonamide group of drugs and Penicillin, with improved obstetric technique, has lowered maternal and fœtal mortality to its present rate.

Turning to gynæcology, I consider that the greatest progress made in the last fifty years has been in the treatment of prolapse. In the early days of medicine it was thought that the uterus was an animal which consumed the sperm, and this was firmly believed by the fathers of medicine. This being the case it was presumed that in cases of prolapse the animal was coming out, and the treatment was to repel it by offending its sense of smell. For this purpose foul-smelling fumigations were employed. If this did not succeed, a type of pessary treatment was employed. Hippocrates advocated the insertion of half a pomegranate. Variations on this were a peeled pomegranate soaked in vinegar, a ball of wool, sponges or animal bladders.

Hippocrates also advocated a more radical treatment : this was to scarify the tissues around the uterus, and then wash the scarred tissue with linen. It is presumed that this caused infection of the tissues around the uterus with subsequent fibrosis, thus pulling up the uterus. The counterpart of this operation was advocated not many years ago, namely the injection of a sclerosing substance into the parametria, and the resulting fibrosis drew up and fixed the uterus.

However, in later years when the anatomy of the uterus was more understood pessaries came into use. In 1472 Mathieu de Garde recommended a metal pessary in the shape of a penis, to be used with astringent lotions. Paré in 1564 described three types of pessary made of various metals, but it is most probable that pessaries were in common use at a much earlier date. There is a record that in 1579 a woman was seen who had retained a cork pessary *in situ* for forty years. Also German women at this period used empty walnut-shells covered in wax, and shaped like a fowl's egg. Even in modern times strange objects are still used. I recently removed from an old lady a ping-pong ball which had been unchanged for four years. This had proved perfectly satisfactory in retaining the prolapse and was perfectly clean. I tried various types of modern pessary, all of which were unsatisfactory to the patient, and in the end I replaced the ping-pong ball, to her great delight.

The cup-and-stem pessary was invented by Jean Bauhin towards the end of the sixteenth century, and modifications of this pessary are used to this day for elderly women in whom operation is contra-indicated. Hodge introduced his pessary in the early nineteenth century and this type or modifications are still used.

Pessary treatment of prolapse was in its heyday when gynæcology first became a speciality. Some of you will remember early gynæcological out-patients—queues of women lining up waiting to have their pessaries removed, cleaned and replaced, or a new one inserted. Students came down an hour before the honorary, and this time was spent in changing "rings". What a change now! Only the occasional pessary to insert, and students even anxious to do it for the sake of practice. The reason for this is the great advance made in operations for repair of the pelvic floor. The early operations were based on suspending or fixing the uterus in the abdominal cavity, and the opening in the pelvic floor was ignored. The result was that the majority of these operations gave only temporary relief, and the prolapse recurred. More exact anatomical knowledge of the pelvic floor and the uterine supports led to the modern operations for pelvic repair. The results of these operations are probably the most gratifying to the patient and operator of any operation in gynæcology, and one gets more thanks for a successful repair than for the removal of the largest abdominal tumour. That the modern operation is successful is shown by the willingness of patients to submit to operation for this lesion, rather than avoid operation by the wearing of a pessary: the opposite was the case not so many years ago.

THE THIRTY-SIXTH LONG FOX MEMORIAL LECTURE

BY

R. MILNES WALKER, M.S.

Professor of Surgery, University of Bristol

DELIVERED IN THE UNIVERSITY OF BRISTOL
ON TUESDAY, OCTOBER 19th, 1948.

ON

SOME ASPECTS OF HOSPITAL ECONOMY

INTRODUCTION

IN 1894, when the British Medical Association held its Annual Meeting in this city, the Presidential Address was entitled: "On the Medical Man and the State." There is hardly a hint in that address of the commercial relations which now bind our profession to the State, there is no hint that up to that time the State had done anything for the medical profession, but most of the address dwells on what medicine had given to the State, the use of vaccination, the warnings about noxious trades, the benefits in public health brought about by the discoveries in bacteriology, and so on; the only reference to financial relations is in connection with the Poor-Law Medical Officer whose salary is described as so inadequate that the State ought never to sanction it; these posts are described as "ill-paid offices filled by men whose knowledge within the education of the present day leaves little to be desired, and whose influence for good excels, if possible, that of the rest of the profession, because exercised under greater difficulties". What would the speaker have to say now, when nearly all the general practitioners of the country, to whom the remarks apply equally well, have been coerced into a gigantic poor-law medical service?

Who was this speaker? None other than Edward Long Fox whose memory we are gathered together to honour to-day.

On looking through the titles of previous lectures I was surprised to find that there was not a single one which dealt with hospitals—and all the more surprised when considering Long Fox's life. For he must have had an intense interest in the organization and management of hospitals, being himself brought up in the atmosphere of the one at Brislington founded by his grandfather, and later serving on the active staff of the Bristol Royal Infirmary.

I would like to digress for a minute to give you my idea of a hospital; its original meaning was "a place of rest and entertainment", later "a charitable institution for the housing and maintenance of the needy, infirm or aged". Such was its use in the Middle Ages, when Bristol was so richly endowed with its Hospitals of St. Lawrence and St. Mary Magdalen for lepers, and of St. Mark, St. John the Baptist, St. Catherine, St. Bartholomew, and Holy Trinity. Incidentally it is worth noting that this last was the only one which was disclaimed by the Minister when the State took them over in 1539.

The subsequent period led to the popular idea of a hospital as defined by Sir Thomas Browne in *Religio Medici:* "For the World, I count it not an Inn, but an hospital, a place not to live in, but to dye in!" (Part II, Sect. 11.)

It was not until the eighteenth century, when so many of our well-known hospitals throughout the country were founded, that the present meaning really came into being. But to those of us who work in hospitals the idea is something different: the hospital is a team of living human beings working together for a common purpose, and given reasonable facilities to do this work, they need not necessarily be housed in marble palaces. We know of such magnificent buildings, where the latest gadgets are provided, where everything is spick and span, yet they hold no reputation as centres either of active research, of good teaching or of well-judged therapy; yet we are surprised very often at the humble places from which great things have come. One black sheep in such a team may mar the reputation of the whole for years, one misfit may disturb the smooth running of a complete hospital unit.

THE NEED FOR HOSPITAL SERVICES

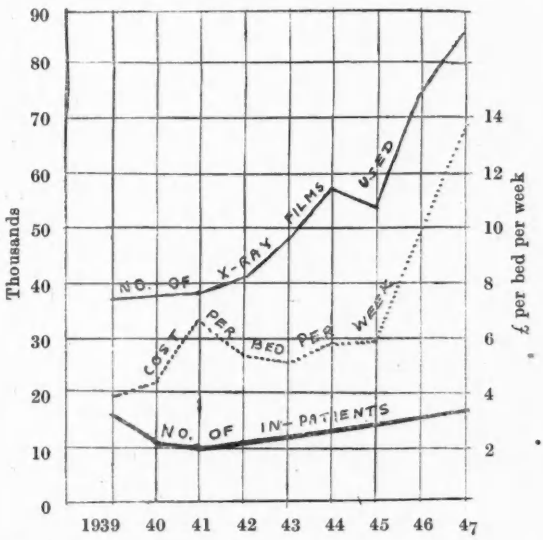
We have so far had no survey which gives us an indication of the need for hospital services; the nearest approach to it has just been published in the survey by the Nuffield Trust of the hospital-treated sickness in Stirlingshire. This gives us the amount of use which is made by the population of the county of the hospital services of this and surrounding districts. We find that in the course of a year one person in every seven made use of the hospital services, either as an in-patient or as an out-patient, while one in every seventeen was an in-patient with an average stay of about thirty days. If you were to take these figures as a basis of the need you would find that the South-Western Region is well supplied with hospital accommodation.

COST OF HOSPITAL SERVICES

No thoughtful person can but be alarmed at the increasing cost of the hospital services. At the Bristol Royal Hospital the cost

per patient per week has risen from under four pounds just before the war to over thirteen pounds now (see chart), and this will in future be considerably greater now that payment is being made for the services of the senior members of the medical staff which hitherto were given voluntarily. A certain amount of the increased cost is due to the great expansion of the ancillary methods of investigation, particularly radiology; but it might be profitable to review all departments with a critical eye. In fact every clinician who is responsible for the charge of patients in hospital should be constantly on his guard against the excessive use of any particular form of investigation or treatment, and must always employ the simple, straightforward methods when these will suffice.

BRISTOL ROYAL HOSPITAL



Another cause for alarm in the increasing cost of hospital services is the steadily rising age of the population. We cannot shut our eyes to the fact that infirmity and the need for hospital admission are greater in the aged than in the young. But there are a great many elderly people now occupying beds in infirmaries throughout the country, who with a little ingenuity and encouragement need not be bedridden, but can be up, and in many cases are capable of providing for their own domestic necessities. The results which have been achieved by Dr. Warren in Middlesex in this direction are remarkable, and no doubt can be repeated in other areas. The

County of Cornwall was already active in this matter before the introduction of the Health Service, and the Regional Hospital Board is taking active steps to face the problem.

SHORTAGE OF NURSING STAFF

And this brings me to the immediate crux of the hospital problem, the shortage of nursing staff. In view of the changing age-groups of the population, I believe that we shall never return to the days when nursing labour will be plentiful, so we must adjust our plans accordingly. By this I do not mean that we should in any way slacken our efforts to recruit more girls to this profession, but that we must look at the problem from the other end as well. For example, we know that many of the chronic sick are exceedingly well looked after by relatives who have no nursing training, but who have merely been shown what to do by a competent district nurse. Thus, though in nursing such patients the supervision of their attention by trained nurses is all to the good, the actual attendance on them can probably be carried out just as well by persons who have had quite a short training. After all, what are the things that matter most to the chronic bedridden patient ? They are the little things, comfort in bed, the adjustment of pillows, personal cleanliness, and above all bright cheerful companionship. What does the three-years' nursing training prescribed by the General Nursing Council provide for these things ? Practically nothing—in fact, it probably detracts from a girl's personality, by its insistence on examinations, just those qualities which we are anxious to preserve and foster. For this type of work I should like to see the Assistant Nurses register retained, but with a shorter and simpler course.

SURGICAL NURSING

For a few moments I crave your indulgence to dwell on my own speciality in medicine. The first aspect I am going to consider is whether it is necessary for nurses to spend part of their time in training at work in an operating theatre; for I see no reason to believe that either the nurse or the hospital would lose anything if this period, which is at present compulsory, were to be excluded from the training. The work in the operating theatres at present done by the nurses can be done by theatre technicians, male or female, specially trained for this purpose, who thus leave nurses to carry out the work for which they are primarily trained—nursing the sick.

There are many other ways by which we can relieve the work of a nurse in a surgical ward, for example, by getting patients out of bed and mobile as early as possible after operation, thus saving those duties for the bed-confined patient, connected with the excretory functions, which are naturally distasteful to patients and nurses alike.

WAITING-LISTS

And now I must touch on the matter of waiting-lists. We have at the moment, to take a single example, on the general surgical waiting-list at the Bristol Royal Hospital, some 1,700 patients. Many of these will never be admitted; by the time that their turn comes they may be dead, they may have moved elsewhere, or perhaps time alone will have healed them. Are we selecting the right patients for the beds which are available? At the moment we give first priority to emergency admissions, accidents and acute illness, patients who are never on the waiting-list at all. Many of them are snatched from death or from prolonged serious disability and soon again return to their active place in the nation's life: it is right that they should be given first priority. Next come sufferers from cancer, and here we must pause to think. Cancer has its appeal. Many patients if treated early can now be cured. But it must be admitted that for the majority our efforts are only palliative: and though these efforts may prolong life, is this period always a happy and comfortable one for the patient? What proportion of these patients as a result of their treatment have been able to return to active normal life? I think that, while encouraging earlier diagnosis in every possible way, we should be very careful in the selection of cancer patients for hospital admission.

On a much lower priority on the waiting-lists are the patients with ruptures and other conditions described as minor ailments—not so minor to the sufferer but so classified because they are unlikely to endanger life, though at the same time they make life a misery, and may greatly impair his usefulness economically. Surely a great effort should be made to catch up with this type of disability. Their place is not in the teaching hospital, for while in-patients they contribute nothing to research or to the training of undergraduates. But I would like to see the Regional Hospital Board alive to its responsibilities regarding this group of patients, and to open a few wards somewhere, with a team of nurses and surgeons, who, as in an operation of war, would set themselves the task of removing this group from the waiting-lists. We might post a team to a small cottage hospital, and give all the patients with minor surgical disabilities who are on waiting-lists the opportunity of admission and early attendance to their case. The turnover would have to be rapid, and any patient who either required additional investigations or developed a complication demanding long-stay treatment would have to be transferred elsewhere. It would be interesting to know how many patients with ruptures or minor ailments of the rectum are on the waiting-lists of hospitals in the South-Western area and to what extent the failure to treat them without delay is influencing industrial efficiency.

Another aspect which deserves consideration is the provision of hostels in connection with our larger hospitals; many patients come from a distance either for special facilities in diagnosis or for some form of treatment which only requires a part of each day and does not necessitate their remaining in bed. A hostel for such patients would be most valuable and would relieve the in-patient beds.

CONCLUSION

I have in this discourse only touched on some of the fringes of our hospital problems: but we cannot start with a clean sheet, and we must for the moment accept many things which are undesirable. However, that is no reason why we should not plan for the future and consider on what basis those plans should be made. An announcement has already been made of an inquiry sponsored by the Nuffield Trust, in co-operation with the University of Bristol, into the function and design of hospitals. It is not for me to attempt any conjecture as to what their findings will be, but that inquiry aims at being practical rather than Utopian, and it will have to take into consideration all the relevant facts. The one which to my mind stands out above all others is that in the future our labour resources are going to be scarce, particularly as regards nursing, and we shall have to make our plans with the incorporation of every labour-saving device, both in construction and equipment, if in the future we are going to make use of our hospitals when built. It is clear that there is a limit to the number of hospital beds which the nation can support, so our plans should be directed to making the most efficient use of these beds. There is nothing to be gained by adding to the number of beds if we cannot provide the labour to make use of them.

But there is the broader problem, as to who should be the inmates of our hospitals. I have already referred to the aged and chronic sick; if they do not go into institutions of some sort where else can they go? I am not going to speak of communal homes for old people, except to say that I consider it a pity to segregate old people from the other age-groups if this can be avoided. At the present time there are people who cannot be bothered to look after infirm relatives, either young or old: they wish to enjoy the pleasures of this world rather than accept its obligations. It has probably always been the same, but I am sure that the problem gets worse as the worldly distractions increase in number and intensity. Many old people are in institutions because their relatives have not the means, either financially or of accommodation, to look after them at home. But there are some who are there because their relatives do not *want* to look after them. The hospital services can only be relieved of the former by better housing and a better standard of

living ; but they could be eased of the latter by a realization of the sense of family obligation. The report by Dr. J. H. Sheldon on Old Age in the Home shows how much is done for old people by their families, particularly amongst the poor, but I am sure that there is room for improvement which would help to relieve the problem of hospital accommodation.

However, we have got to face the fact that the cost of the hospital services is going to be a very heavy burden, and there are going to be some shocks when the figures become known, for the estimates made by the Ministry of Health are a long way short of the mark. But in the long run the limiting factor will not be finance, but labour. As bureaucracy absorbs an increasing proportion of the man-power, less and less remains for productive work. We have got to see that the administration of our hospital services is kept as small as is consistent with an efficient service, and that those trained in its technical aspects, particularly doctors and nurses, are not side-tracked from their useful and economical employment into the administrative machine.

Now that the State has taken over the responsibility of the hospital services, I cannot do better than quote from that presidential address which was delivered fifty-four years ago by Long Fox. " Happy is the State," said he, " that legislates in all things concerning the welfare of the people in dependence on medical advice. As a profession . . . we concern ourselves with the well-being of the masses of mankind, the possibilities of the advancement of the race, the annihilation of those things that militate against the progress of the nation. Our highest ambition is to leave each generation better than we found it, and by the results of our investigations and by the influence of our lives to form foundations for our successors to rise higher still, and to elevate the race to a point impossible for ourselves, to deserve to have it said of each one of us, as it was of the great head of our profession, ' He went about doing good, healing all that were diseased, for God was with him '."* May the State take note of this advice, and may our profession continue to uphold these ideals in our new relationship with the hospitals.

THE QUADRUPLETS: I. DELIVERY

BY

H. L. SHEPHERD, Ch.M., F.R.C.O.G. AND

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Obstetricians, Bristol Royal Hospital
Visiting Obstetricians, Southmead Hospital.

MRS. M. G. was admitted to Southmead Hospital on 10th June, 1948, with well-marked symptoms of toxæmia of pregnancy. She was a tall, well-built woman of twenty-seven. There was one daughter aged two, born after a normal pregnancy and labour.* Mrs. G.'s last menstrual period had been on 10th October, 1947. All through this pregnancy her abdominal enlargement had been unusually great and a multiple pregnancy had been suspected, but a skiagram taken at the end of March had shown only one fœtus.

On admission, her blood pressure, which had been observed to be rising during the previous three weeks, was 170/100. There was marked œdema and albuminuria. The girth of the abdomen was 47½ inches and palpation strongly suggested a triple pregnancy. A skiagram taken on the morning of 11th June quite clearly showed four fœtal heads.

There was a definite increase in the œdema and albuminuria during the next twenty-four hours, accompanied by a further rise in the blood pressure to 180/105, with severe headache and blurring of vision. This rapid increase in symptoms suggested the wisdom of a rapid delivery. A classical Cæsarean section was therefore performed under cyclopropane anæsthesia. Apart from some difficulty in rupturing the fourth sac this presented no unusual problems. The patient made a rapid recovery, the toxæmic symptoms disappearing within three days.

[An illustrated account of this is published in *The Nursing Times 17.7.48. XLIV, 29.*]

* For further family history see "Notes," p. 18.

THE QUADRUPLETS: II. MANAGEMENT

BY

BERYL D. CORNER, M.D., M.R.C.P.

Physician, Bristol Royal Hospital for Sick Children; Pædiatrician, Southmead Hospital.

ON the morning of 12th July, 1948, the Premature-Baby Unit staff at Southmead Hospital was informed that quadruplets were to be delivered by Cæsarean section at 2.0 p.m. Four "Sorrento" type premature-baby cots were prepared, heated to 90° F. and fitted with oxygen tents. The first three babies, Bridget, Frances

PLATE III

THE QUADRUPLETS: X-RAY FILM

The arrows point to outline of fourth head

and Elizabeth, cried immediately on delivery, were wrapped in warm sterile towels and placed in their cots. The fourth child, Jennifer, was in a state of blue asphyxia which persisted for four minutes. About one and a half ounces of fluid were aspirated from her respiratory passages by a rubber mucous catheter and laryngoscope, and a stream of oxygen was directed into her pharynx before she gasped and shortly afterwards started regular respiration. All babies were given Synkavit 1 c.cm. intramuscularly and then transferred to the Premature Unit, where the air temperature is maintained at 75° F. and humidity 65 per cent.

During the first twelve hours occasional aspiration of mucus was necessary, but the children cried well and gave rise to little anxiety. The usual premature-baby nursing and feeding technique was employed, which included turning the infants two-hourly in their cots and giving oxygen with 7 per cent. carbon dioxide inhalations at the same time to stimulate respiration. The use of oxygen tents was discontinued on the seventh day. Minimum skin cleaning was carried out with sterile liquid paraffin, and the babies were clothed in flannel gowns and hoods.

Feeding was begun after twelve hours with sterile water, one drachm by bottle two-hourly. Although at first sucking was satisfactory, on the second day there was a tendency to regurgitate, and therefore four-hourly feeding by œsophageal tube with diluted human milk (quarter-strength) was employed. Bottle feeding was resumed three-hourly on the fourth day, giving eight feeds in twenty-four hours. The strength and quantity of human milk was increased daily till on the seventh day the children were taking two ounces per pound of body weight. Owing to the tendency to relaxed stools full-strength milk was not given until the ninth day. By the fourteenth day three ounces per pound of body weight was taken in seven feedings daily, some of the milk being supplied by the mother, the remainder being pooled human milk.

At the end of the third week the decision was made that, in view of the psychological and practical problems involved in singling out one child for breast feeding, human milk should be gradually discontinued. Frailac was therefore introduced slowly, with some added protein as skimmed dried milk for the three bigger children and casein hydrolysate 2 per cent. for Bridget. At six weeks all babies were fully fed on Frailac, three ounces per pound of body weight daily, with protein additions. During the subsequent fortnight a gradual changeover was made to "Special" half-cream "Cow and Gate" dried milk (protein 3·4 per cent., fat 1·8 per cent., lactose 4·9 per cent.), to which was added half a drachm of cane-sugar in each feed, and the number of feeds was reduced to six daily. At eight weeks all babies were receiving approximately sixty calories per pound per day.

During the twelfth week full-cream " Cow and Gate " milk feeds were begun, so that the complete change was effected by fourteen weeks, and, at the same time, the two larger children were reduced to five feeds daily (seven ounces per feed), cane-sugar one drachm and glucose half a drachm being added to each feed.

Owing to the considerable risk of vitamin and iron deficiencies occurring, three supplements were introduced early. Ascorbic acid 10 mgm. daily was started on the seventh day and increased daily up to 50 mgm. by the fourteenth day. High potency vitamin D and calcium (900 units vit. D) was started at the same time and increased up to 3,600 units vitamin D after three weeks. Neoferrum minim i daily was begun at four weeks and increased to minims v at sixteen weeks. The hæmoglobin has been estimated weekly from the seventh day and has remained well up to normal levels.

During the third week of life the children were transferred to a cooler nursery, temperature 65°–70° F., and were placed on the ward balcony, weather permitting. On the ninety-sixth day they were discharged from hospital to two " farm-worker " type council houses specially adapted for the family. The infants were nursed throughout their stay in hospital by the staff of the Premature-Baby Unit, supplemented in the later stages by two nurses who had previously worked in the unit and who went home with them to continue their care.

TABLE I

WEIGHT

	Birth		7 Days		12 Days		48 Days		96 Days		133 Days	
	lb.	oz.	lb.	oz.	lb.	oz.	lb.	oz.	lb.	oz.	lb.	oz.
1. Bridget ..	3	13	3	9½	3	14	5	10	8	14½	12	1½
2. Frances ..	4	0¼	3	11½	3	15	6	2	9	8½	13	1
3. Elizabeth	4	8	4	4	4	10	6	8	9	15	13	5
4. Jennifer ..	3	14	3	10	3	14	5	13	8	14	12	3½

TABLE II

HÆMOGLOBIN PERCENTAGES

	7 Days	21 Days	35 Days	84 Days	121 Days
1. Bridget ..	140	116	100	80	88
2. Frances ..	140	104	84	88	92
3. Elizabeth ..	152	135	120	86	96
4. Jennifer ..	136	115	110	92	90

Postscript. February 9th. Bridget has cut her first tooth.

PLATE IV

THE QUADRUPLETS

[*Photo by P.A.—REUTER Photos Ltd.*

Jennifer Bridget Frances Elizabeth

THE QUADRUPLETS. III.—NOTES

BY

E. J. WATSON-WILLIAMS, B.A.

Sometime obstetric clerk, Southmead Hospital.

The placenta is large, measuring 36 x 23 cm. It consists of a main part, roughly circular with a diameter of 23 cm., attached to which is a somewhat quadrilateral portion about 15 x 13 cm.: a well-marked groove on both faces separating the two. One cord is attached to the smaller and thinner portion. The area of the larger part remote from the smaller (amounting to about one-third) is marked off by a slight straight ridge arranged chordwise. Two umbilical cords are attached to the central, largest, part at some distance from each other, the fourth springing from the smaller division of the large circular mass. The membranes consist of a separate chorion and amnion for the quadrilateral portion (probably belonging to the infant delivered last); a chorion including two amniotic sacs for the central portion, and a chorion and amnion for the small division of the large part, the chorion of this apparently fused with the middle chorion where these are in contact. It may be inferred that these four children result from fertilization of three ova, the middle pair being "identical" or uniovular twins.

I wish to thank Mr. H. L. Shepherd for permission to use this material.

Frequency. The remarkable feature of this case is that quadruplets were carried so near full term. Toxæmia of pregnancy, premature labour, and fœtal mortality are considerably greater in twin than in single pregnancy, very much more with triplets, etc. The frequency of multiple births is shown in the table.

WHITE BIRTHS IN U.S.A. 1922–36.[1]

	All	Twins	Triplets	Quadruplets
Total births ..	28,244,869	630,460	9,123	196
Live births ..	27,338,663	588,810	8,010	158
% still-births ..	3·13	6·1	12	20
% males, all births	51·6	50·9	50·0	52·6
% males, live births	51·4	50·6	49·4	50·6
Pregnancies ..	27,920,030	315,230	3,041	49
Frequency (all births)		1 : 88·6	1 : 9,150	1 : 570,000
Cf. Veit 13,000,000 births[2]		1 : 80	1 : 7,910	1 : 371,126
Berkeley, etc.[3] ..		1 : 90	1 : 7,628	1 : 670,734

"There are only fifty-one cases of quintuplets on record, thirty-two authenticated. All babies died: except in one group all died within the hour; in another only one lived (for fifty days); the third group is the Dionne family. There are well-authenticated cases of six and seven children born at one confinement, but all died."[3]

The third line of the table illustrates well one effect of multiple pregnancies: still-birth ratio is doubled with each additional fœtus. The next two lines show that, contrary to popular belief, the proportion of male babies is only very slightly less in multiple than in single pregnancies.

There is a very definite hereditary tendency to multiple pregnancies: either mother or father may be responsible. Mrs. G.'s mother's mother had identical twin girls, and Mr. G.'s mother's sister had boy-and-girl twins. One woman produced twins three times, triplets six times and twice quadruplets: she was one of quadruplets and her husband himself a twin. The Russian Wasilef had by his first wife quadruplets four times, triplets seven times and twins sixteen times: and by the second triplets twice, and twins six times. Another Russian peasant, Kirilow, had by his first wife quadruplets four times, triplets seven times, and twins six times. A Frenchman had triplets seven times by his wife and once by his mistress.[2]

Influence of Sex.[2] Uniovular or "identical" twins are little more than half as frequent (10/17) as binovular, resulting from fertilization of two ova.* Triplets can result from fertilization of one, two or three ova: the second is the most frequent, with one pair of identical twins and another baby from a second ovum. Uniovular quadruplets, etc., are rare: nearly all such multiple births result from fertilization of two or three ova, as in the case reported above. The Dionne quintuplets were *probably* uniovular.

All uniovular twins are like-sexed: but in addition more than half binovular twins are like-sexed, as though difference in sex were a factor inimical to survival. A similar tendency occurs in triplets, where unlike sex is unusual and still more in quadruplets, etc., where it is rare.

Survival brings out a definite difference between the sexes. The neonatal mortality is much greater for twins than for single births: for female twins it is about 12 per cent.; for males nearly 50 per cent., four times as great. The difference is greater as the number of babies increases: hence very few males survive from quadruplet, etc., births.

"It is a popular opinion . . . that if twins be of different sexes, the female is sterile". Simpson[5] investigated the possibility of the occurrence in humans of a sterile intersex female, analogous to the free-martin in cattle: and showed that there is no ground for belief that such a condition occurs in humans. Of 123 women born co-twin with males 112 had families, i.e. only 10 per cent. of their marriages were infertile—exactly the figure for marriages of single-birth women in the same area: the co-twin mothers averaged slightly more children than the others.

From Dr. A. R. Dafoe's description of the birth of the Dionne quintuplets:[4] "At 4 a.m., May 28th (1934) a 'hurry' call came from the Dionne home . . . two babies had already been born and a third was just making its appearance over the perineum. A kettle of water boiling was the sole preparation for the labour. I took over the situation and delivered the third baby. In the meantime another amniotic sac

* Crew, F. A. J., gives proportions which differ considerably from these. *Practitioner*, 1947, i, 233.

was presenting itself at the vaginal orifice, and a little pressure over the abdomen brought another baby into the world. This one was followed by still another. The last two babies were born within intact amniotic sacs. . . . Apart from shock and some post-partum hæmorrhage, and later a phlebitis in the right saphenous vein, the mother did well. The placenta was single, irregular in outline, with the cords emerging from it at various points: unfortunately it was destroyed. The babies appear to resemble one another considerably, and all are girls, still alive and thriving. Their combined weight at birth was 13 lb. 6 oz."

REFERENCES

[1] Strandskov and Siemens, "Sex-Ratios at birth in U.S.A., 1922-36." *Amer. Jl. Physical Anthropology*, 1947, p. 491.

[2] Browne, F. J., *Antenatal and Post-natal Care*, London, 1946, p. 159.

[3] Berkeley, Bonney and Macleod, *Abnormal in Obstetrics*, London, 1937, p. 283.

[4] *Jl. A.M.A.*, 1934, Sept., p. 673.

[5] *B.M.J.*, 1949, 1, p. 49—quoting *Selected Obstetrical and Gynaecological Works of Sir J. Y. Simpson*, Edinburgh, 1871, p. 822.

Editorial Notes

Veterinary School Buildings.

"And Samuel said, What meaneth then this bleating of the sheep in mine ears, and the lowing of the oxen which I hear?" It is encouraging to observe that, a Professor of Veterinary Medicine having been appointed, a start has already been made with the buildings that the Department will require. We may begin to hope that at no very distant date it will be possible to restore the damage done to the Medical School and the Bristol General Hospital during the war.

* * * * *

Medical Library.

The new and revised edition of the Laws and By-Laws of the Bristol Medico-Chirurgical Society is being printed, and copies should be in the hands of members at an early date. To our other readers the chief interest lies in the concession made in a recent agreement with the University of Bristol: this extends to all subscribers to the *Journal* the privilege of borrowing books from the extensive medical library by post. The conditions are set out on a later page: this amenity applies only to individuals, not to institutions.

Reviews of Books

A Synopsis of Physiology. By A. Rendle Short, B.Sc., M.D., F.R.C.S., C. L. G. Pratt, O.B.E., M.A., M.D., M.Sc., and C. C. N. Vass, M.Sc., Ph.D., M.B., Ch.B. Fourth Edition. Pp. x, 346. Illustrated. Bristol: John Wright & Sons Ltd. 1948. 20s.—It is difficult to praise this book, since Physiology cannot be satisfactorily presented in the form of a synopsis; yet some success has undoubtedly been achieved in condensing the subject-matter and bringing it reasonably up to date, so as to serve as a convenient aid in revision. It cannot take the place of a text-book. The ground is well covered, though there are some obvious omissions. Gout is not mentioned in the section on purine metabolism; and, as an example of the omission of important evidence, no reference is made to the results of cannulation of the capsule in the mammalian kidney or of other parts of the nephron.

On the whole, the balance is well preserved. A large amount of space is devoted to colour vision hypotheses. As might be expected in a book of this kind, the style leaves something to be desired. One particularly bad sentence reads : " Isletectomy may be obtained after pancreatectomy, or injection of extracts of anterior pituitary gland or alloxan." Here and there teleological statements appear where reasoned views, even if only brief, should be given. The format is handy, and the lay-out and printing are excellent ; the few diagrams are clear. There are several misprints which should be corrected in the next edition.

Infra-red Irradiation. By WILLIAM BEAUMONT, M.R.C.S., L.R.C.P. Third Edition. Pp. xii, 162. Illustrated. London : H. K. Lewis & Co. Ltd. 1948. 8s. 6d.—Students of physiotherapy will welcome this new edition of Dr. Beaumont's very readable little text-book on radiant heat. It has been considerably revised and the layout improved ; printing, paper and binding remain excellent. The physical basis, which many students find difficult, might be more fully explained. On pages 35 and 36 appear the remarkable statements that red rays are the shorter visible and blue rays the longer ! The correct description is on page 60. There are a few references to literature on the text pages, but a full bibliography would be a useful addition. The index is inadequate.

Introduction to Diseases of the Chest. By JAMES MAXWELL, M.D., F.R.C.P. Third Edition. Pp. xii, 307. Illustrated. London : Hodder & Stoughton Ltd. 1948. 12s. 6d.—The subject-matter of this book is well balanced, and the method of presentation is clear and concise, full use being made of paragraph headings and tabulation. The third edition has brought it up to date, particularly regarding penicillin therapy in respiratory infections. All these points commend it for the use of the student or practitioner, who desires fuller information on the subject than the average text-book gives. It is, therefore, the more unfortunate that the first complication of lobar pneumonia to be considered is lung abscess, and that for the treatment of " delayed resolution " it is thought necessary to suggest needling of the lung—a hazardous procedure at the best of times, especially if as an outside possibility a lung abscess were developing. There are, however, very few such points to detract from the soundness of the teaching in this most useful volume. A good selection of skiagrams is adequately reproduced at the end of the book, which is very moderately priced, considering the high standard of publication.

The Background of Therapeutics. By J. HAROLD BURN, M.D., F.R.C.S. Pp. vii, 367. Illustrated. London : Oxford University Press (Geoffrey Cumberlege). 1948. 22s. 6d.—Every now and again an outstanding book is published dealing with Clinical Medicine, a book that matters to every physician, to every general practitioner, and to every teacher in any branch of Medicine and Surgery. Professor Burn has chosen for discussion a few examples of the bearing which ascertained pharmacological fact has upon the practice of medicine and

surgery. Teachers of the older generation stand at the bedside and speak as pundits to the young students, who often must know how out of date the pundits' pharmacology has become, and preserve a respectful but doubting silence. Here is a book for older clinicians to read with humility and the younger ones with apprehension, for, if they do not take care, their knowledge, too, will be found out of date.

A Surgeon's Guide to Local Anæsthesia. By C. E. CORLETTE, M.D., Ch.M., F.R.A.C.S. Pp. xi, 355. Illustrated. Bristol: John Wright & Sons Ltd. 1948. 30s.—It is a great pity that this excellent book is given the sub-title of "A Manual of Shockless Surgery," thus giving the impression that the author is prone to exaggeration; it leads the reader to think that local anæsthesia is applicable only to those less severe operations in which the other factors which cause shock do not play a part, or that extravagant claims are being made. As a guide to the technique of local anæsthesia it is thorough and complete. In the early chapters there is a general review of the subject, and the reader is reminded of the dangers of spinal anæsthesia even when compared with chloroform. Stress is laid on the value of careful premedication, and on the use of adrenalin, and practical advice is given regarding the dangers of confusing various solutions. It is surprising that the need for an adequate syringe service using only syringes sterilized in an autoclave is not stressed. The actual technique of local anæsthesia is admirably described and well illustrated, and emphasizes the detailed knowledge of anatomy required. The anæsthesia devised for cystoscopy sounds complicated and might lead to trouble where there is infection of the urinary tract, and the use of the cautery for excision of hæmorrhoids is rarely employed nowadays. This book will with advantage be read by all surgeons, and should encourage those who rarely employ local anæsthesia to give it a wider trial. It can be recommended as an excellent guide to the technique.

Meetings of Societies

BRISTOL MEDICO-CHIRURGICAL SOCIETY

THE Annual General Meeting was held at the University on Wednesday, 13th October, 1948. The retiring President proposed from the chair the election of Professor J. A. Nixon as an Honorary Member. He reminded members how seldom this honour was bestowed, and how much the Society was indebted to Professor Nixon for his work on the staff of the *Journal* during thirty-nine years, for twenty-two of which he was Editor: these years included the difficult period of the last war. The proposal was carried by acclamation.

The new President, Professor H. J. Drew Smythe, then delivered his Presidential Address, published on page 1 of this issue.

The annual reports of the honorary secretary, honorary treasurer and editor were read and approved, and the first two were thanked for their labours during the past year and re-elected. Three members were elected to vacancies on the Committee, and other officers as shown below :

Committee, 1948–49

President : Professor H. J. Drew Smythe. *President-Elect :* Dr. Orr-Ewing. *Honorary Treasurer :* Dr. Sutton. *Honorary Secretary :* Mr. Eyre-Brook.

Editor of " Journal " : Mr. Watson-Williams. *Assistant Editor :* Dr. N. S. Craig (*ex-officio*).

Honorary Medical Librarian and Representatives on Library Committee of the University : Professors Perry, Milnes Walker and Drew Smythe.

Elected Members : Mr. R. V. Cooke, Mr. A. Palin, Mr. Elwin Harris, Dr. Rowley, Dr. Lennox Robertson, Professor Milnes Walker, Dr. Kersley, Dr. V. Tryon, Dr. Cornall.

HONORARY SECRETARY'S REPORT

During the year 1947–48 there were sixty-three new members elected, bringing the total membership to 351. We have lost two valued members through death—Mr. Carwardine and Mr. Clifford Moore.

The President (Dr. T. Milling) gave an exceedingly interesting address on " The Life of Edward Jenner ", illustrated by material he had collected from the Welcome Institute and from his own visits to Berkeley, where Jenner lived and worked. The Clinical Meeting was again held in the form of demonstrations, but this year at the Royal Fort instead of the Bristol Royal Infirmary, as formerly. Distinguished visitors who addressed the Society were Professor W. W. D. Thompson and Mr. J. J. Mason Brown. Papers were contributed by Dr. Coralie Rendle Short, Dr. Malcolm Campbell, Dr. Clarke and Dr. Naish, Professor Rendle Short, Dr. Gibson and Dr. Norman.

During the course of the year Professor Nixon resigned the Editorship of the *Bristol Medico-Chirurgical Journal*. The Committee of the Society were delighted to obtain the services of Mr. Watson-Williams as the new Editor. I am sure we are all delighted to welcome him and none will be ignorant of the many years of hard work that he has put into the *Journal*, both as Assistant Editor and as Editorial Secretary.

BRISTOL MEDICO-CHIRURGICAL SOCIETY

INCOME AND EXPENDITURE ACCOUNT for the year ended 30th September, 1946

EXPENDITURE

	£	s.	d.
To Subscriptions to *Medico-Chirurgical Journal* (255 at 10s. 6d.)	133	17	6
,, Grant to Medical War Relief Fund	250	0	0
,, Librarian, Honorarium	22	10	0
,, Secretary and late Secretary, Honorarium	20	10	0
,, Audit Fee	4	4	0
,, Printing and Stationery	23	10	10
,, Lewis's Medical and Scientific Library	6	7	6
,, Catering (£ s. d. 49 18 9)			
,, Other expenses of Meetings (15 6 10)			
,, Postages and Sundries (24 18 4)			
	90	3	11
	£551	3	9

INCOME

	£	s.
By Members' Subscriptions	237	1
,, Interest on Bank Deposit Account	1	2
,, Interest on £500 4 per cent. Consolidated Stock, *less* Tax	10	10
,, Deficiency for the Year	302	10
	£551	3

BALANCE SHEET as at 30th September, 1946

LIABILITIES

	£	s.	d.	£	s.	d.
Sundry Creditors				26	8	0
Due to *Journal* for 1945, on Account				9	13	11
Subscriptions paid in Advance				3	3	0
Capital as at 30th Sept., 1945	1,130	4	8			
Less Deficiency for the year	302	10	5			
				827	14	3
				£866	19	2

ASSETS

	£	s.	d.	£	s.	d.
Cash in Hand				3	3	0
Cash at Bank—						
Current Account	195	19	6			
Deposit Account	190	9	8			
				389	12	
£500 4 per cent. Consolidated Stock at cost				437	9	
Arrears of Subscriptions				39	18	
				£866	19	

Audited and found correct,
H. E. KEELER,
Chartered Accountant
Auditor.

16–18 Clare Street, Bristol 1.
October, 1946.

In the Winter issue for 1946 (p. 154) it was announced that the Treasurer's Report would appear in next issue: by an oversight it was omitted. The Accounts and Balance Sheet of the Society are therefore given here.

BRISTOL MEDICO-CHIRURGICAL SOCIETY

INCOME AND EXPENDITURE ACCOUNT for the year ended 30th September, 1948

EXPENDITURE	£	s.	d.	INCOME	£	s.	d.
Subscriptions to *Medico-Chirurgical Journal* handed over	356	0	0	By Members' Subscriptions	560	3	6
Grant to Medical Library	25	0	0	,, Interest on Bank Deposit Account		14	2
Librarian, Honorarium	15	0	0	,, Interest on £500 4 per cent. Consolidated Stock, *less* Tax	11	0	0
Secretary	10	0	0	,, Deficiency for the year	46	13	7
Audit Fee	8	8	0				
Printing and Stationery	61	5	2				
Lewis's Medical and Scientific Library	8	2	3				
Catering	98	4	3				
Other Expenses of Meetings	18	16	11				
Postages and Sundries	17	14	8				
	£618	11	3		£618	11	3

BALANCE SHEET as at 30th September, 1948

LIABILITIES	£	s.	d.	£	s.	d.	ASSETS	£	s.	d.	£	s.	d.
Sundry Creditors	27	9	6				Cash at Bank—						
Subscriptions paid in advance	16	16	0				Current Account	14	6	8			
Cash due to the *Journal*	69	16	11				Deposit Account	91	8	6			
Accumulated Fund as at 30th Sept., 1947	640	15	11								105	15	2
Less Deficiency for the year	46	13	7				Petty cash in hand				10	3	1
				594	2	4	£500 4 per cent. Consolidated Stock at cost				437	9	0
							Arrears of Subscriptions				154	17	6
				£708	4	9					£708	4	9

Audited and found correct,

H. E. KEELER,

Chartered Accountant,
Auditor.

16-18 CLARE STREET, BRISTOL 1.
October, 1948.

The second meeting of the session was held at the University on Wednesday, 10th November. Professor A. V. Neale read a paper entitled: **"Early Life"**, which we hope to publish in our next issue.

A proposal was submitted for borrowing books from the Library by post, for the convenience of members living out of Bristol, and approved.

The third meeting was a clinical meeting at the University on Wednesday, 8th December. Professor Milnes Walker, **"Coarctation of the Aorta"**; Dr. A. M. G. Campbell, **"Neurological Cases"**; Mr. R. V. Cooke, **"Patients Surviving several years after Gastrectomy for Carcinoma"** (Mr. A. W. Adams showed another case); the Streptomycin Research Team, **"Results of Treatment of Tuberculosis Meningitis"**; Dr. J. M. Naish, **"Hemi-Parkinsonism"**; Mr. A. L. Eyre-Brook, **"Repair of Cut Flexor Tendons"**.

The President presented the new edition of Laws and Bye-Laws, which were approved by the Society.

The fourth meeting was held at the University on Wednesda y 12th January, 1949. Professor Milnes Walker gave an address on **"Surgery in Vascular Disease"**, illustrated by lantern slides, which we hope to publish shortly. The meeting confirmed the alterations in the Laws approved at the previous meeting, and passed a vote of thanks to Mr. Watson Williams for the work he had done in the revision.

DEVON AND EXETER MEDICO-CHIRURGICAL SOCIETY

ON 16th December Dr. F. M. R. Walshe gave an address on **"The Clinical Approach in Neurology."** *v. B.M.J.*, 1949, i, p. 27.

PLYMOUTH MEDICAL SOCIETY

ON 11th March: Mr. Lambert Rogers (*subject to be announced*).

BRISTOL MEDICAL ASSOCIATION (BATH, BRISTOL AND SOMERSET BRANCH)

THE annual meeting of the above Branch was held at Taunton on 25th November. Mr. J. R. Nicholson-Lailey delivered his Presidential Address entitled: **"Some Points in the History of Taunton and Somerset."** The officers for the year are: President, Mr. J. R. Nicholson-Lailey, F.R.C.S.; President-Elect, Dr. Percy Phillips; Vice-Presidents, Dr. R. G. Gordon and Dr. H. J. Orr-Ewing; Hon. Secretary, Dr. O. E. L. Sampson; Hon. Treasurer, Dr. C. H. G. Price.

A meeting of the branch was held at Musgrove Park Hospital, Taunton, on Saturday 29th January. Mr. J. Barron. F.R.C.S. gave an address on "Plastic Surgery."

The main item of interest in the Branch Council report was the comment on the extremely successful meeting held at Bath in February, 1948. Mr. Justice Birkett addressed in a most interesting and amusing manner a record attendance of 270 members.

Forthcoming meetings: The meeting scheduled for 23rd February at Bath will be held on 16th February instead.

A clinical meeting is being arranged at the Bristol Royal Infirmary for 30th March.

BRITISH MEDICAL ASSOCIATION (BRISTOL DIVISION)

A GENERAL meeting of the Division was held at the University on Wednesday, 17th November. It was devoted to a film show: "Patent Ductus Arteriosus; Anterior Poliomyelitis; Pathé News Reel of Southmead Quadruplets."

On 27th April Professor Henry Cohen will deliver a lecture in the large physics theatre (Royal Fort). The subject will be announced later.

THE SOUTH-WESTERN LARYNGOLOGICAL ASSOCIATION

THE first meeting of the session was held on 2nd October, 1948, at the Gloucester Royal Infirmary, Mr. Watson-Williams in the chair. Eleven members and three visitors were present. A number of interesting cases were shown by Messrs. Gibb, Barker and Mower: notably, brother and sister with hereditary syndactyly and scleroderma, and œsophageal stricture: and several cases illustrating results obtained by radiotherapy.

The second meeting of the session was held on 8th January at the Royal Gwent Hospital, Newport. Messrs. Sutton and J. L. D. Williams showed several series of cases: (*a*) after operation for brain abscess; (*b*) bone complications of frontal sinusitis; (*c*) maxillary osteomyelitis in infants; (*d*) keratosis laryngis; (*e*) deafness after meningococcal meningitis; and a number of others. A lively discussion took place.

The next meeting of the Association will be on 2nd April, at Bournemouth.

Local Medical Notes

HONOURS

O.B.E. Wing-Cdr. H. B. Porteous, M.B., Ch.B.

APPOINTMENTS

Professor R. H. Parry has been appointed adviser to the American Mission to Greece, for the reorganization of hospital and health services in that country.

Dr. K. Cowan, County M.O.H. for Essex.

Dr. B. A. Astley Weston, M.O.H., Bath, has been elected President of the West of England branch of the Society of Medical Officers of Health.

Dr. C. D. Evans, O.B.E., M.B., B.Ch., and Mr. R. P. Warin, M.D., M.R.C.P., Dermatologists, United Bristol Hospitals.

Mr. J. R. A. White, M.B., Ch.B., F.R.C.S., Surgeon, West Cornwall Hospital.

Dr. N. R. W. Simpson, M.B., B.S., Director of Physical Medicine, N. Gloucestershire.

Dr. J. A. Pitt Evans, M.B., B.S., B.Sc., Pathologist, Cheltenham.

Dr. J. Macrae, M.D., Physician-in-Charge, Ham Green Hospital, Bristol.

EXTRACTS FROM REGULATIONS FOR THE MEDICAL LIBRARY AND FOR THE BORROWING AND RETURN OF BOOKS

Borrowing by Post.—Any member of the Bristol Medico-Chirurgical Society or subscriber to the *Journal* (being a Registered Medical Practitioner) *residing in Great Britain more than* 10 *miles from the University building*, shall have the right to borrow books from the Medical Library subject to the following provisions:

1. The member or subscriber wishing to borrow a book shall apply in writing to the Superintendent, The Medical Library, The University, Bristol 8.
2. He shall state clearly, for a book, the author, title and year, and for a periodical, the title, volume and date. (All names in BLOCK CAPITALS.)
3. He shall add an undertaking to return the book(s) in good order and to make good any loss or damage.
4. He shall enclose sufficient money for packing and postage; one shilling for one book, and a further 6d. for each additional book—a heavy volume to be counted as two.
5. He shall return the books, securely packed, by Registered Post, addressed to the Superintendent (as above) at once if requested, and in any case not more than three weeks from the day of despatch.

MEDICAL DINNER

A medical reunion dinner has been arranged, to be held on 20th April, 1949: for members of the Bristol Medico-Chirurgical Society and all former students of the Bristol Medical School. Will those who wish to attend please notify the Secretary of the Society at once? It will be a great help if those who read this notice will bring it to the attention of any former students they may know.

BRISTOL HOSPITALS' RUGBY CLUB

The Bristol Medical Rugby Club has been refounded. During the war years it had completely lapsed. For many years previous to 1940 there was a flourishing Club connected with the local Medical School, and the Royal Infirmary and General Hospital ran separate teams, which met annually in a memorable series of matches. The present Club has been named The Bristol Hospitals' Rugby Club, and the officers are: Hon. President, Mr. W. M. Capper; Hon. Treasurer, Mr. Ashton Miller; Captain, Mr. M. E. Hincks. Membership is open to anyone connected with the Hospitals of Bristol in any way. The side has been considerably helped by many postgraduates, and the junior staff is well represented in most of the games. The Club has already played several local teams, and fixtures are planned with Hospital sides at Oxford and in London. The team settled down well from the beginning of the season, and the match record to date is: Played, 12; won, 5; lost, 5; drawn, 2.

DEGREES AND DIPLOMAS

University of Bristol.—

M.B., CH.B.—R. J. Carey, Anne B. Cousins, Vera H. M. Dowling, D. N. FitzGerald, Margaret Ford, Anne M. French, B. T. Hale, G. A. Hanks, Kathleen J. Harrison*, Joan A. Higginbottom, Una P. Jones, A. H. Laxton, A. J. Lee, D. B. Peacock, Elizabeth Preston-Thomas, G. T. Salter, P. J. Speller, G. D. Teague, A. S. Wallace, Pamela L. C. Watson, Maro A. Wells.

B.D.S.—D. C. Sara.

D.P.M.—M. A. X. Cocheme, V. G. Crotty, W. A. Heaton-Ward.

L.D.S.—D. Clifford, L. B. Howell, H. T. Ivory, J. P. B. Pengelly.

D.M.R.D.—D. M. P. R. Clarke. (We desire to apologize to the practitioner, whose name was wrongly given in the last issue, for what we hope was only intelligent anticipation.)

[* With Distinction in Public Health.]

University of Cambridge. M.D. O. C. Lloyd, P. D. Samman.

Royal College of Surgeons. F.F.A. Dr. G. L. Feneley.

F.D.S. Mr. John Wells.